

**Kittitas Valley Community Hospital**

Patient Accounting

Financial Assistance Policy

16997

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(Rev: 0) In preparation

MAR 19 2007DEPARTMENT OF HEALTH
Center for Health Statistics

Policy

POLICY

Kittitas Valley Community Hospital is committed to the provision of health care services to all persons in need of medical attention regardless of ability to pay. In order to protect the integrity of the operations and fulfill this commitment, the following criteria for the provision of financial assistance, consistent with the requirements of the Washington State Hospital Association, are established. This criteria will assist staff in making consistent objective decisions regarding eligibility for financial assistance.

This program helps support individuals and families with hospital expenses. Our program provides financial assistance in the form of free or reduced-price hospital care, depending on income.

COMMUNICATIONS TO THE PUBLIC

Kittitas Valley Community Hospital's Financial Assistance Program shall be made publicly available through the following elements:

1. A notice advising individuals and families that the hospital has financial assistance available shall be posted in key areas of the hospital including Registration, Emergency Department, Emergency Department waiting area and the Outpatient waiting area.
2. The hospital will distribute a written notice of the hospital's financial assistance program and sliding payment schedule to individuals and families at the time the hospital requests information pertaining to third party coverage. If for some reason, for example in an emergency situation, the patient is not notified of the existence of the financial assistance program before receiving treatment, he/she will be notified in writing thereafter. All uninsured patients will receive the financial assistance notice in their first billing from the hospital.
3. The hospital shall train front-line staff to answer financial assistance questions effectively or direct such inquiries to the Patient Accounting Department.
4. Written information about the Financial Assistance Program and the sliding payment schedule shall be made available to *any person* who requests the information, either by mail, telephone, e-mail or in person.

ELIGIBILITY CRITERIA

Individuals and families with incomes that meet our guidelines are eligible if they: do not have financial resources to pay for care; are not generally insured, i.e., covered by a group or individual medical plan, Worker's Compensation, Medicare, Medicaid, or any other state, federal, or military program; and are not involved in a situation where someone else has a legal responsibility to pay for the costs of medical services (e.g. an auto accident).

In situations where appropriate primary payment sources are not available or have been exhausted, individuals and families shall be provided financial assistance under this hospital policy based on one of the following standards:

- The full amount of hospital charges will be adjusted for a patient whose gross family income is at or below

100% of the current federal poverty level; or

- A sliding payment schedule will be used to determine the amount of hospital charges that will be adjusted for patients with incomes between 101 and 300 percent of the current federal poverty level; or
- The hospital may adjust the full amount of hospital charges for patients with family income in excess of 100% of the current federal poverty level when circumstances indicate severe financial hardship or personal loss.

The responsible party's remaining financial obligation after the application of the sliding payment schedule will be payable at minimum monthly payment of 10% of remaining balance. The responsible party's account will not be referred to a collection agency unless the responsible party defaults on the minimum payment or the hospital is unable to make mail or telephone contact with the responsible party.

PROCESS FOR ELIGIBILITY DETERMINATION

A. Initial Determination:

1. The hospital will use an application process for determining eligibility for financial assistance. Requests to provide financial assistance will be accepted from either the patient, responsible party, physicians, community or religious groups, social services and/or patient accounting personnel, provided that any further disclosure of the information contained in the request shall be subject to the Health Insurance Portability and Accountability Act, Privacy Regulations and the hospital's Privacy Policies.
2. The initial determination of eligibility for financial assistance can be completed prior to admission, at the time of admission, following completion of treatment or as soon as possible after receiving the original billing.
3. Pending final eligibility determination, the hospital will not initiate collection efforts or request deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a final determination.

B. Final Determination:

1. Financial Assistance applications shall be furnished to the responsible party when financial assistance is requested, when need is indicated, or when financial screening indicates potential need. All applications, whether initiated by the responsible party or the hospital, should be accompanied by documentation to verify information indicated on the application form. Any one of the following documents will be considered sufficient evidence on which to base the final determination:

- Pay stubs from employment; or
- A "W-2" withholding statement; or
- Last year's income tax return; or
- Letters approving or denying Medicaid, medical assistance; or
- Letters approving or denying unemployment compensation; or
- Written statements from employers or welfare agents.

2. During the initial request period, the patient and the hospital may pursue other sources of funding, including Medicaid and legal liability situations. The responsible party will be required to provide written verification of eligibility for all other sources of funding.

3. Usually, the relevant time period for which documentation will be requested will be three months prior to the date of application. However, if such documentation does not accurately reflect the applicant's current financial situation, documentation will only be requested for the period of time after the patient's financial situation changed.

4. In the event that the responsible party is not able to provide any of the documentation described above, the hospital will rely upon written and signed statements from the responsible party for making a final determination of eligibility.

5. The hospital will allow a patient to apply for financial assistance at any point from pre-admission to final payment of the bill, recognizing that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in the need for financial assistance.

6. In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital can establish that the applicant's income is clearly within the range of eligibility, the hospital will grant financial assistance based solely on the initial determination. In these cases, the hospital is not required to complete full verification or documentation.

C. Time frame for final determination and appeals:

1. Each financial assistance applicant who has been initially determined eligible for financial assistance, will be given at least fourteen calendar days, or such time as may reasonably be necessary, to secure and present documentation in support of his or her financial assistance application prior to receiving a final determination.
2. The hospital will notify the applicant of its final determination within twenty-one days of receipt of the application and supporting documentation.

D. Adequate notice of denial:

1. When an application for financial assistance is denied, the responsible party will receive a written notice of denial, which includes:
 - The reason or reasons for the denial;
 - The date of the decision; and
 - Instructions for appeal or reconsideration.
2. The responsible party may appeal the determination of eligibility for financial assistance by providing verification of income or family size to the Patient Account Representative within thirty days of receipt of notification.
3. The Patient Account Manager and the Chief Financial Officer will review all appeals. If this review affirms the previous denial for financial assistance, written notification will be sent to the responsible party and the Department of Health.

DOCUMENTATION AND RECORDS

1. If a patient has been determined to be eligible for financial assistance and continues receiving services for an extended period of time, the hospital will re-evaluate the patient's eligibility for financial assistance at least annually to confirm that the patient remains eligible. The hospital may require the responsible party to submit a new financial assistance application.
2. Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.
3. Documents pertaining to the financial assistance shall be retained for five years.

Referenced Documents

Reference Type	Title	Notes
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Created	01/17/2007	
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Document Owner		
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Brunner, Deb		
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<http://www.lucidoc.com/cgi/doc-gw.pl/ref/kvch:16997>

KITTITAS VALLEY COMMUNITY HOSPITAL
Financial Assistance
2007/2008 Sliding Payment Schedule

Modified										
Family Size	Less Than	More Than	But Less Than	More Than	But Less Than	More Than	But Less Than	More Than	But Less Than	More Than
1	10,400	10,400	13,832	13,832	17,264	17,264	20,800	20,800	31,200	31,200
2	14,000	14,000	18,620	18,620	23,240	23,240	28,000	28,000	42,000	42,000
3	17,600	17,600	23,408	23,408	29,216	29,216	35,200	35,200	52,800	52,800
4	21,200	21,200	28,196	28,196	35,192	35,192	42,400	42,400	63,600	63,600
5	24,800	24,800	32,984	32,984	41,168	41,168	49,600	49,600	74,400	74,400
6	28,400	28,400	37,772	37,772	47,144	47,144	56,800	56,800	85,200	85,200
7	32,000	32,000	42,560	42,560	53,120	53,120	64,000	64,000	96,000	96,000
8	35,600	35,600	47,348	47,348	59,096	59,096	71,200	71,200	106,800	106,800
9	39,200	39,200	52,136	52,136	65,072	65,072	78,400	78,400	117,600	117,600
10	42,800	42,800	56,924	56,924	71,048	71,048	85,600	85,600	128,400	128,400
Patient Responsibility	0%	20%		40%		60%		75%		100%



KVCH Financial Assistance Program: **Help for individuals and families with hospital expenses.**

What is the KVCH Financial Assistance Program? This program helps to support individuals and families with hospital expenses. Our program provides financial assistance in the form of, free or reduced-price hospital care, depending on your income.

Who is eligible for financial assistance? Individuals and families with incomes that meet our guidelines are eligible if they:

1. Do *not* have financial resources to pay for care;
2. Are *not* generally insured, i.e., covered by a group or individual medical plan, Worker's Compensation, Medicare, Medicaid, or any other state, federal, or military program; and
3. Are *not* involved in a situation where someone else has a legal responsibility to pay for the costs of medical services – for example, an auto accident.

Important Note: KVCH does not discriminate based on age, sex, religion, marital status, race, color, national origin, veteran status, sexual orientation or disability.

What does the KVCH Financial Assistance Program cover? Our financial assistance covers necessary or emergency hospital care. It covers inpatient and outpatient hospital care.

It does *not* cover transportation costs, elective procedures, and usually does not cover doctors' services.

How do I apply? To find out what is needed to establish eligibility, and what services will be covered, please contact:

**Patient Accounting Department
Kittitas Valley Community Hospital
509-962-9841
Monday – Friday 8:00 AM to 4:00 PM**

Kittitas Valley Community Hospital provides hospital care to anyone, regardless of ability to pay.



KITTITAS VALLEY COMMUNITY HOSPITAL

Application for Financial Assistance

Kittitas Valley Community Hospital encourages you to apply for Financial Assistance if you need help paying hospital charges for inpatient or outpatient care. Financial Assistance may offer free care or reduced-price care based on your eligibility and income. *If you have questions or need help completing this application, please call Patient Accounting at 509-962-9841.*

Please Print

Personal Information

Patient's Name: _____

If patient is a minor or a dependent, print name of parent or other responsible party: _____

Mailing Address: _____

City: _____ Telephone Number: _____

Number of people in family (living in household): _____

Health Insurance Information

Medical Insurance? Yes _____ No _____ If "yes," Name of Insurance Company:

Is the medical treatment because of a car accident or injury for which someone else is legally responsible?

Yes: _____ No: _____

Is the medical treatment because of an on-the-job injury or accident?

Yes: _____ No: _____

Income: Be sure to include with your application documents that give the income amounts you list. For example:

- Pay stubs from employment; or
- A "W-2" withholding statement; or
- Last year's income tax return; or
- Letters approving or denying Medicaid, medical assistance; or
- Letters approving or denying unemployment compensation; or
- Written statements from employers or welfare agents.

Current family monthly income (before taxes are taken out): \$ _____

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three months?

Yes: ____ No: ____ If yes, please describe: _____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property)?

Yes: ____ No: ____ If yes, please explain: _____

Do the documents that you are including with this application show your current financial situation correctly?

Yes: ____ No: ____ If no, why not? _____

If you are asking for Financial Assistance for services already provided by Kittitas Valley Community Hospital, please list dates of services and what services you received:

I understand that the information I am giving will be verified by Kittitas Valley Community Hospital and reviewed by state and/or federal enforcement agencies and others as required by law. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature _____ Date _____

Mail this application with all documentation to:
Kittitas Valley Community Hospital
Patient Accounting
603 S Chestnut
Ellensburg, WA 98926